

# A New Ethical Dilemma: Veterans with Post-Traumatic Stress Disorder

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## OVERVIEW

Ethical dilemmas, while dilemmas present opportunities for innovations in clinical practice. Decisions are made in the thorny ethical and intellectual terrain of what is "right versus what is right." Ethical and clinical dilemmas are ultimately positioned upon the horizon of values. Practitioners are faced with the question; "which 'right'" is most 'right'?

When in disagreement, each side is usually firmly rooted in one of society's basic core values. It taps into the values that define us both personally and professionally. If we practice healthcare, it is inevitable that we confront issues involving ethical dilemmas. "We" as a collective and "I" as the decision maker must land on the side of "right for the patient in front of us." The current "state of care" is perhaps historically one of the greatest crevices. How do we allocate precious resources in an era of such scarcity? For example, increased funding to our troops has been a constant concern. Many believe that those who defend our country should be taken care of, no matter what the cost. Approximately 69.4 billion dollars have been appropriated for veterans in the fiscal year 2005. However, there are others who believe we are paying too much and that we should not be at war. Still others believe veterans may be "scamming" the system to receive more than they deserve.<sup>1</sup> This article discusses the ethical dilemma that revolves around diagnosing, treating and allowing compensation for veterans with posttraumatic stress disorder (PTSD).

## ETHICAL Dilemma

In 2005, in response to a review by the VA's Office of the Inspector General (OIG), the VA agreed to review post traumatic stress disorder cases in which the veteran was awarded disability compensation at the 100% rate between the years 1999-2004. The review was precipitated by the OIG's findings that the VA had failed in some cases to obtain all required evidence to fully document decisions to award or increase disability compensation for PTSD. The VA Inspector General was quoted as saying that PTSD determinations were based on subjectivity and subjectivity leads to inconsistency.<sup>2</sup>

Over the years, there has been much controversy with the diagnosis of PTSD as a mental illness. Currently, PTSD is a diagnostic category under the DSM IV-Revised.<sup>3</sup> Numerous studies have been conducted in an attempt to extrapolate the emotional cost of war.<sup>4,5,6</sup>

The lifetime prevalence of PTSD among Vietnam veterans has been estimated at 30%.<sup>7</sup> The prevalence of PTSD among Gulf War veterans is estimated at 10%.<sup>8</sup> The prevalence of PTSD among veterans deployed to Somalia is estimated at 8%.<sup>9</sup> The prevalence in Iraq and Afghanistan is 17%.<sup>10</sup> For the fiscal year 2004, the VA spent 4.3 billion dollars for PTSD disability payments excluding medical care. However, the controversy continues on whether PTSD should even be conceptualized as a long term disability. This ethical dilemma leaves us with the challenge to accurately diagnose, and treat those who have the problem, conserve resources by identifying those who do not and finally to ensure appropriate allocation of resources for all veterans.

## ANSWERS

The use of narrative is invaluable when attempting to sort through the complexity of accurately identifying, diagnosing and treating PTSD. The techniques generated from the model of narrative medicine offer a fresh view at a longstanding dilemma.<sup>11</sup> That dilemma is whether and how to incorporate the subjective into the differential diagnostic process. Narrative and the primacy of language in human experience are ubiquitous, often go unnoticed, and are lost as a diagnostic tool.<sup>12</sup>

Narrative knowledge is what one uses to understand the meaning of stories by examining cognitive, symbolic and affective themes. Narrative deals with experiences not propositions or structured clinical interviews. The patient's story is central. It is that story and the language within that serves to contain disorder and gives shape to the chaos of illness, including PTSD. Listening to the narrative thread allows the clinician to recognize multiple and often contradictory meanings of words used and events described. The clinician lets the story unfold; looks for the minute detail; and determines the plausibility, authenticity and coherence of the trauma narrative. Plausibility is gauged by asking questions of the trauma narrative: could this have happened to this person, at this place and in this time? Authenticity is often determined by observation. Does this patient look and act in a way that is consistent with other patients with PTSD? Is this the patient quietly sitting in the corner of the waiting room with his back to the wall and a clear shot at the door? Is the narrative coherent and linear? Research and anecdotal reports indicate that most narratives of trauma are not. Attention to the use of narrative

in clinical interviews can assist in the identification of patients with PTSD and concurrently account for the problem of "being subjective." PTSD is by nature subjective and in the realm of the subjective that providers can perhaps use most effectively.

## CONCLUSION

Ethical dilemmas will continue in healthcare and clinicians will continue to face "right vs right" decisions. We practice in an era of scarcity. More people need more services and there are diminishing human and financial resources yet the events of the world are increasingly traumatizing and re-traumatizing for the combat veteran. In times of scarcity it is incumbent upon us to practice in ways that are smarter, visionary and creative. It is through those means that we identify those who need treatment and to further identify those patients whose circumstances are truly and current disabling.

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